

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

HEPSERA (adeforvir dipivoxil)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**DOCUMENTATION FROM PROGRESS NOTES OR LETTER OF
MEDICAL NECESSITY**

CRITERIA:

- ▶ Diagnosis of hepatitis B
- ▶ Failure on Epivir

INFORMATION:

10mg/day max dose.

AUTHORIZATION:

Initial prior is for 12 weeks.

RE-AUTHORIZATION:

12 months with a telephone call from physician's office

